R590. Insurance, Administration.
R590-175. Basic Health Care Plan Rule. (Effective 2-8-08)
R590-175-1. Authority.

This rule is issued pursuant to Subsection 31A-22-613.5(2) and the general rulemaking authority vested in the commissioner by Section 31A-2-201. Section 31A-22-613.5(2)(a) requires that the commissioner adopt a Basic Health Care Plan.

R590-175-2. Statement of Purpose and Scope.

(1) The purpose of this rule is to adopt a Basic Health Care Plan as:

(a) a conversion plan per Section 31A-22-723; or

(b) a basic coverage plan per Section 31A-30-109.

(2)(a) This rule applies to all insurers marketing health insurance policies subject to the open enrollment provisions of Chapter 30; and

(b) to all insurers subject to 31A-22-723.

R590-175-3. General Requirements.

(1) Each insurer who is required to offer a health care plan under the open enrollment provisions of Chapter 30 shall file with the department at least one basic health care plan which is specified by the insurer as complying with the provisions of this rule and which must be offered for sale to anyone qualifying for open enrollment under Chapter 30.

(2) The basic health care plan shall not be designed or marketed in a manner that tends to discourage its purchase by anyone the open enrollment provisions of Chapter 30.

(3) A plan having actuarial equivalence may be considered, at the sole discretion of the commissioner.

(4) Each insurer must use the language in this rule to present covered services, limitations and exclusions.

(5) A plan offered in compliance with the open enrollment provisions of Chapter 30 must contain at least the benefits set forth in the Basic Health Care Plan as adopted by the commissioner.

(6) The basic health care plan is to be offered as a package, in its entirety, and is mutually exclusive of and not comparable on a line by line basis to an insurer's other plans.

(7) If the basic health care plan is offered by a preferred provider organization, PPO, the benefit levels shown in the plan are for contracting providers; benefit levels for non-contracting providers' services may be reduced in accordance with Section 31A-22-617.

(8) Each insurer is to include its usual contracting provisions in its basic health care plan including submission of claims, coordination of benefits, eligibility and coverage termination, grievance procedures general terms and conditions, etc.

(9) Each insurer who is required to offer a group conversion plan under Subsection 31A-33-723 shall file with the department at least one basic health care plan that complies with the provisions of this rule and must be offered for sale to anyone qualifying for conversion.

(10) The form to follow for the Basic Health Care Plan is as follows:

TABLE
BASIC HEALTH CARE PLAN

1. MAXIMUM BENEFIT. The maximum benefit per person for the entire period for which this policy coverage is in effect shall be $1,000,000.

2. ANNUAL MAXIMUM BENEFIT. The maximum annual benefit per person shall not be less than $300,000.

3. OUT OF POCKET MAXIMUM PER PERSON. The annual out of pocket maximum per person shall be $5,000, including any deductibles, copayments or coinsurances in the plan.

4. PREEXISTING CONDITION LIMITATION.

(a) Any preexisting condition limitation shall be in compliance with Utah Code Subsection 31A-22-605.1(4); and

(b) Any waiting period shall not exceed 12 months with credit for prior coverage when applicable.

5. GENERAL COST-SHARING FOR MEDICAL BENEFITS.

(a) Cost-sharing shall be based on eligible expenses;

(b) The cost-sharing features of the plan shall be the following:

(i) Annual Deductible

(A) The major medical deductible may not be less than $1,500 per person

(B) An annual deductible for prescription benefits may not be less than $500 per person.

(ii) Copayment.

(A) A copayment is not less than $25 per visit for office visits, including preventive care services.

(B) A copayment is not less than $150 per visit to the emergency room.

(iii) Coinsurance. For all covered services other than prescriptions, the person shall pay not less than 20% coinsurance for office visits and 20% per emergency room visits

6. PREVENTIVE SERVICES. Preventive services covered under a managed care plan shall not be subject to the annual deductible. Covered preventive services shall consist of at least the following:

(a) childhood immunizations in accordance with guidelines as recommended by the Centers for Disease Control, as directed and modified from time to time;

(b) well-baby care through age five in accordance with guidelines recommended by the American Academy of Pediatrics, as directed and modified from time to time;

(c) for adults and adolescents, age, sex and risk appropriate preventive and screening services in accordance with Classification A guidelines recommended by the U.S. Preventive Services Task Force, as directed and modified from time to time.

7. COST SHARING FOR PRESCRIPTION DRUGS. Benefits for prescription drugs, other than self injectable drugs, except insulin, shall be subject to either:

(a) a copayment of not more than:

(i) the lesser of the cost or $15 for the first tier of

drugs;

(ii) the lesser of the cost or_$30 for the middle tier of drugs and

(iii) the lesser of the cost or $60 for the highest tier of drugs; or

(b) a coinsurance of not less than:

(i) the lesser of the cost or 25% for first tier drugs;

(ii) the lesser of the cost or 40% for middle tier drugs; and

(iii) the lesser of the cost or 60% for the highest tier of drugs.

8. COST SHARING FOR MENTAL HEALTH BENEFITS. Benefits for mental health services will be provided only on conversion policies issued from group health plans offering mental health benefits and at the same level of the group policy.

9. OUTPATIENT REHABILITATION SERVICES. Benefits for outpatient rehabilitation services, e.g., physical therapy, occupational therapy, and speech therapy, shall be limited to not less than 10 visits for each illness or injury.

10. HOME HEALTH CARE. Benefits for home health care shall be limited to not less than 30 days in any 12 month period and shall consist of services provided, in accordance with a plan of care, in the home by a licensed community home health agency or an approved hospital program for home health care when the person is physically unable to obtain necessary medical care on an outpatient basis, would otherwise be confined as an inpatient, and is under the care of a physician. A "plan of care" means a written plan that:

(a) is approved by the physician prior to commencement of treatment, unless it is continuity of care under the same physician;

(b) is based on the assessment data or physician orders; and

(c) identifies the patient's needs, who will provide needed services, how often, treatment goals, and anticipated outcomes. Covered services shall not include health aide services furnished when the person is not receiving professional services of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN), nor shall it include housekeeping services.

11. DURABLE MEDICAL EQUIPMENT. Benefits for durable medical equipment, rental or purchase, at the option of the insurer. Prosthetics and orthotics shall be limited to not less than $5,000 per person for the entire period for which coverage is in effect.

12. COVERED SERVICES. Subject to medical necessity, provider network, and prior approval criteria established by the insurer, and subject to the limitations and exclusions and other terms and conditions of the policy, the following shall be covered services under the basic health care plan:

(a) inpatient hospital services:

(i) semi-private room accommodations;

(ii) ICU;

(iii) hospital services and supplies;

(b) ambulatory service facility services:

(i) birthing center services, when maternity care is covered;

(ii) surgical facility services;

(c) office preventive services;

(d) office medical services:

(i) diagnostic services; e.g., x-ray, lab tests;

(ii) therapeutic services; e.g., injection of medication;

(e) outpatient hospital services:

(i) emergency room services;

(ii) diagnostic services;

(iii) therapeutic services; e.g., chemotherapy, radiation therapy;

(iv) surgical facility services;

(f) inpatient medical services; e.g., physician visits;

(g) surgery;

(h) assistant-at-surgery;

(i) anesthesia, including children's general anesthesia for dental, if necessary;

(j) consultation;

(k) dental care for accidental injury to sound natural teeth;

(l) limited home health care;

(m) emergency ambulance transportation;

(n) prescription drugs;

(o) durable medical equipment, prosthetics and orthotics, as limited; and medical supplies;

(p) maternity services:

(i) for employer group~~s~~ conversion plans, maternity benefits are provided on the same basis as benefits for sickness;

(ii) for individual~~s~~ plans, there are no maternity benefits;

(iii) benefits for complications of pregnancy are provided on the same basis as benefits for sickness. Complications of pregnancy will not be excluded solely because the pregnancy is a preexisting condition. "Complications of pregnancy" means diseases or conditions, the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy. Complications of pregnancy does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy. In no event will the presence of complications of pregnancy result in benefits being provided for services normal to care and treatment of pregnancy and childbirth. Such normal services include but are not limited to hospitalization for childbirth or termination of pregnancy by any means, anesthesia services, ultrasound examinations, prenatal diagnostic laboratory services, antepartum and postpartum care, vaginal or cesarean delivery, threatened premature termination, premature termination, and routine nursery care of the newborn;

(iv) newborn and maternity inpatient time limits will conform to Subsection 31A-22-610.2. For conversion plans, maternity will be covered with the lesser of benefits originally on plan prior to conversion or the basic benefit plan. This coverage benefit is only for existing pregnancies, known or

unknown at the time of conversion. Additional premium for pregnancy is not allowed;

(q) limited outpatient rehabilitation services;

(r) limited mental illness/substance abuse services;

(s) diabetes as required by Section 31A-22-626.

(t) inborn metabolic errors, PKU, nutritional benefits as required by Section 31A-22-623; and

(u) mastectomy as required by Sections 31A-22-630 and 31A-22-719.

13. EXCLUSIONS. Benefits will not be provided for any of the following:

(a) services, supplies, or treatment provided prior to the effective date or after the termination date of coverage;

(b) charges in connection with a work-related injury or sickness for which coverage is provided under any state or federal worker's compensation, employer's liability, or occupational disease law;

(c) services, supplies, or treatment for which coverage is provided under any motor vehicle no-fault plan. When the person is required by law to have no-fault insurance in effect, this exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;

(d) services, supplies, or treatment for injury or sickness resulting from war or any act of war whether declared or undeclared;

(e) services, supplies, or treatment for injury or sickness resulting from service in the military of any country;

(f) services, supplies, or treatment for which benefits are provided under Medicare or any other government program except Medicaid;

(g) services, supplies, or treatment for which no charge is made or for which the person is not required to pay;

(h) services or supplies not incident to or necessary for the treatment of injury or sickness or which are not medically necessary, as determined by the insurer;

(i) treatment or prevention of an injury or sickness, including mental illness, by means of treatments, procedures, techniques, or therapy outside generally accepted health care practice;

(j) services, supplies, or treatment required as a result of an injury or sickness sustained while committing a felony or engaging in an illegal occupation;

(k) services to the extent benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service related medical conditions;

(l) examinations, reports, or appearances in connection with legal proceedings; and services, supplies, or accommodations pursuant to a court order, whether or not injury or sickness is involved;

(m) investigative/experimental technology, treatment, procedure, facility, equipment, drug, device or supply, "technology," which does not, as determined by theinsurer on a case by case basis, meet all of the following criteria:

(i) the technology must have final approval from appropriate governmental regulatory bodies, if applicable;

(ii) the technology must be available in significant number outside the clinical trial or research setting;

(iii) the available research regarding the technology must be substantial. For purposes of this definition, "substantial" means sufficient to allow the insurer to conclude that:

(A) the technology is both medically necessary and appropriate for the person's treatment;

(B) the technology is safe and efficacious; and

(C) more likely than not, the technology will be beneficial to the person's health;

(iv) the regional medical community as a whole must generally recognize the technology as appropriate;

(n) services in connection with any transplant of any whole organ or part thereof, live or cadaver, bone marrow, either as donor or recipient, or any artificial organ, except for the following:

(i) cornea transplants;

(ii) kidney transplants;

(iii) liver transplants for children under age 18 years;

(iv) bone marrow transplants for children under age 18 years; and

(v) evaluation, treatment and therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support for children under age 18 years;

(o) custodial care;

(i) "Custodial care" means:

(A) institutional care, consisting mainly of room and board, which is for the primary purpose of controlling the person's environment; and

(B) professional or personal care, consisting mainly of non-skilled nursing services with or without medical supervision, which is for the primary purpose of managing the person's disability or maintaining the person's degree of recovery already attained without reasonable expectation of significant further recovery.

(ii) "Custodial care" does not mean outpatient palliative and supportive care provided by a hospice program to a person who is terminally ill with a life expectancy of not more than six months and is in lieu of institutional or inpatient hospital care;

(p) services, supplies, or treatment in connection with cosmetic or reconstructive procedures which alter appearance but do not restore or improve impaired physical function or which are performed for psychological or emotional purposes, except when performed while a person is covered under this policy for the following:

(i) repair of defects resulting from an accident occurring within 90 days of the effective date of this policy under creditable coverage or occurring during this policy;

(ii) replacement of diseased tissue surgically removed for illness occurring within 90 days of this policy under creditable coverage or occurring during this policy;

(iii) treatment of a birth defect in a child who has met the pre-existing conditions requirement since birth or date of placement for adoption; and

(iv) mastectomy reconstruction as required by Sections 31A-22-630 and 31A-22-719;

(q) dental services. This exclusion will not apply if dental services are required as a result of an accidental injury which occurs while coverage is in force, dental services are received within two years following the accidental injury, and the person has been continuously covered from the date of the accidental injury through the date the dental services are provided;

(r) eyeglasses, contact lenses and/or servicing of eyeglasses and/or contact lenses. This exclusion does not apply to contact lenses in the case of keratoconus or post-cataract surgery when the contact lenses are medically necessary in the treatment of the condition;

(s) medical, non-surgical, care of weak, strained, flat, unstable or unbalanced feet routine foot care. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(t) orthopedic or corrective shoes, foot orthotics, or any other supportive devices for the feet;

(u) drugs and medicines which do not bear the legend "Caution - federal law prohibits dispensing without a prescription" and/or which are not dispensed by a licensed pharmacist;

(v) charges in connection with jaw realignment procedures including, but not limited to, osteotomy, upper or lower jaw augmentation or reduction procedures, and orthognathic surgery; charges in connection with treatment of temporomandibular joint (TMJ) dysfunction, including surgical procedures and injections of the TMJ, physical therapy, splints, and orthodontic appliances. This exclusion will not apply to:

(i) the initial diagnostic evaluation of TMJ dysfunction;

(ii) surgical correction of the TMJ required as a result of an accidental injury which occurs while this coverage is in force; and

(iii) physical therapy services related to and subsequent to covered TMJ surgery;

(w) treatment of obesity by means of surgical, medical or medication services and regardless of associated medical, emotional, or psychological conditions;

(x) services or supplies in connection with genetic studies;

(y) implantable contraceptives (hormonal or other);

(z) reversal of a sterilization procedure;

(aa) any treatment for or diagnosis of infertility, artificial insemination, in vitro fertilization, and any other male or female dysfunction, except as required by Section 31A-8-101;

(bb) vision testing, vision training;

(cc) radial keratotomy, laser and any surgical correction of

errors of refraction;

(dd) educational service or counseling, including weight control clinics, stop smoking clinics, cholesterol counseling, exercise programs or other types of physical fitness training, except for those benefits required by Section 31A-22-626;

(ee) marriage counseling; family counseling; counseling for educational, social, occupational, religious, or other similar maladjustment; behavior modification, biofeedback, or rest cures as treatment for mental disorders; sensitivity or stress-management training; self-help training; and residential treatment;

(ff) treatment for mental disorders which are irreversible or for which there is little or no reasonable expectation for improvement, including mental retardation, personality disorders, and chronic organic brain disease. This exclusion does not apply to the initial assessment for diagnosis of the condition;

(gg) psychotherapy, counseling, or other services in connection with learning disabilities, disruptive behavior disorders, conduct disorders, psychosexual disorders, or transexualism. This exclusion does not apply to the initial assessment for diagnosis of the condition;

(hh) vitamins, special formulas, special diets, and food supplements except as provided by a hospital or skilled nursing facility during a confinement for which benefits are available, except as outlined in Section 31A-22-623;

(ii) any devices used to aid hearing, including cochlear implants, the fitting of such devices and any routine hearing tests;

(jj) acupuncture or acupressure;

(kk) speech therapy for psychosocial speech delays;

(ll) all shipping, handling, or postage charges except as incidentally provided, without a separate charge, in connection with covered services or supplies;

(mm) interest or finance charges except as specifically required by law;

(nn) charges for missed appointments, telephone consultations, and clerical services for completion of special reports or claim forms;

(oo) travel expenses, whether or not prescribed;

(pp) care, except urgent or emergency care, rendered outside the United States;

(qq) services provided by a member of the person's immediate family or household; and

(rr) autopsy procedures.

(11) The basic health care plan is to be filed with the department before use.

(12) Conversion coverage provided pursuant to Section 31A-22-723, may provide additional benefits in addition to the Basic Health Care Plan.

R590-175-4. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule 45 days from the rule's effective date.

R590-175-5. Severability.

If a provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected.

KEY: insurance
Date of Enactment or Last Substantive Amendment: 2007
Notice of Continuation: November 8, 2005
Authorizing, and Implemented or Interpreted Law: 31A-22-613.5